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**Title: Health promotion by communities and in communities: current issues for research and practice**

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## **Abstract**

This paper explores contemporary issues around community-based health promotion in the light of international health policies reaffirming the central role of community action within broader efforts to achieve health equity. Adopting a system level approach poses challenges for current health promotion practice and evaluation, particularly where there is a shift in emphasis from small scale community health projects towards mainstream community programmes, capable of engaging widely across diverse populations. Drawing on research with community members carried out by the Centre for Health Promotion Research, Leeds Metropolitan University, UK, the paper re-examines assumptions about the nature of interventions within community settings, and what participation means from a lay perspective. Key research issues for community-based health promotion are highlighted. The paper concludes by proposing that community-based interventions need to be reframed, if the dual challenges of citizen involvement and evidence based practice are to be met.

## **Keywords**

community participation; volunteering; health promotion; health systems; assets; health champions; walking groups; evidence

**Word count: 3294**

## **Introduction**

Community participation is a central tenet of health promotion practice, stemming from an ideological position that seeks to shift power over health away from professional dominance within a bio-medical paradigm towards a social model that creates the conditions where people have greater control over their health and wellbeing. Settings based approaches entail consideration of the role of communities in health promotion within specific social contexts. Community participation can be a component of multi-sectoral and multi-level action across a local health system, for example within Healthy Cities [1], but also communities can be deemed a setting for health promotion in healthy neighbourhoods [2]. The implications are that community-based health promotion has to be more than a programmatic response to meet health goals. Recent health policies in Europe and globally have set out a further agenda, one that reaffirms the central role of civil society within broader efforts to achieve health equity [3, 4]. Adopting what is in essence a system-level approach that places communities more centre stage poses challenges to develop interventions that are both grounded in community (local) concerns but capable of engaging widely across diverse populations. In Europe, such approaches need to fit within contexts where health systems are being challenged due to economic conditions, and politically in relation to calls for greater citizen involvement in governance [5]. This paper explores contemporary issues for building research and practice around community-based health promotion within wider health systems and advances an argument for reframing social action using a ‘people centred’ rather than an ‘intervention driven’ perspective. This is not just a case of ‘reinventing the wheel’, as the paper builds on current understandings and highlights the areas of challenge where solutions are uncertain. It goes on to explore the nature of interventions within community settings and lay perspectives on participation, drawing on research conducted at the Centre for Health Promotion Research, Leeds Metropolitan University, UK. Finally, the implications for

research and practice are discussed in terms of linking local action with systemic approaches such as characterise settings approaches.

### **Contemporary challenges**

Taking community-based health promotion forward within a European context requires some understanding of the current state of knowledge. This section briefly summarises four major themes around community participation where there is either a level of consensus or a body of knowledge, before going on to identify contemporary challenges and areas where uncertainties exist.

First, there is broad agreement on the value of participation and the central role of communities in health promotion. The justifications have been well advanced over the years and relate to core goals around achieving social justice and enabling people to gain greater control of their own health [6, 7]. In contrast to managerialist approaches where participatory methods are used to address functionalist goals [8], health promotion approaches acknowledge the constitutive value of participation as part of an equitable and democratic health system [7] .

Second, we now have a nuanced understanding of what the concept ‘community’ mean [9], and how social networks and social ties are important factors for health [10]. There is recognition that communities may be identity-based as well be place-based [11], and that uncritical use of the term ‘community’ may risk, as Fremeaux argues in a critique of the New Labour UK government, citizens being ‘reduced to a specific and institutionally defined

identity' that ultimately may exclude the voice of marginalized groups [9]. Furthermore, in an article on 'unpacking participation', Cornwall [12] argues that participation of community members is a dynamic process with many facets to consider.

Third, good evidence for various participatory approaches exists and continues to grow, often informed and driven by communities of practice working in these areas. There is a distinct evidence base for citizen participation in the Healthy Cities movement [1, 13], and for other intervention types, for example lay health worker programmes [14] and participatory action research [15]. Evidence relates not only to questions of effectiveness but also to process issues about how communities are best engaged.

Fourth, even in economically developed and relatively wealthy countries, there remain persistent health inequalities. Community participation and empowerment are recognised strategies to achieve greater equity in health, in part because approaches built on the concept of empowerment seek to address the powerlessness faced by disadvantaged and under-served communities [6]. Nevertheless, participatory approaches are working against economic drivers, particularly in some European states, that will lead to greater inequality.

These themes reflect some aspects of the current knowledge base, but there are contemporary challenges for community-based health promotion where solutions are either uncertain or where knowledge gaps exist. This paper identifies three questions where there is scope for development of ideas.

*(i) The place of community within a public health system – what does that mean?*

The notion of a public health system has been used to explain the networks, resources and structures that exist across different sectors that in combination represent organised efforts to improve health and prevent disease [16]. Communities are, of course, a vital part of any public health system, but it is not always clear what that means for health promotion practice. Current health policy reflects a shift of emphasis from community involvement activities to considering the broader role of civil society linked to a whole-of-society, whole-of-government approach to health. The new WHO Europe ‘Health 2020’ policy framework stresses collaborative governance and states that ‘civil society is a key actor in formulating, promoting and delivering change’ [4:5]. In a similar vein, the Rio Political Declaration on Social Determinants of Health [3:4] pledges to ‘consider the contributions and capacities of civil society to take action in advocacy, social mobilization and implementation on social determinants of health’.

A recent WHO Europe review by Kickbush and Gleicher [5] provides an analytical framework for developing governance around health and wellbeing encompassing individual and collective levels. These sophisticated understandings of health systems, society-wide approaches and governance need to be translated into health promotion interventions which place the citizen at the heart of health. For community-based health promotion, we need to question whether practice is reflecting contemporary understandings of community as an essential part of a health system [16] or health ecology [17], or is still seeing ‘community’ in traditional terms as a resource, a (target) population, or as setting.

*(ii) How can community-based health promotion have an effect on health inequalities at a population level?*

The challenge of Rio and Health 2020 is to enable social action on health as part of wider strategic efforts to achieve equity in health. While this is conceptually coherent and resonates with healthy settings approaches, there remains a tension between local, developmental work that enables specific communities to engage in health and wellbeing activities, and the scale of efforts required to address population-level health inequalities [18:149-153]. Greater involvement of civil society necessitates a shift in emphasis from small scale community health projects towards mainstream community programmes, capable of engaging widely across diverse populations. There is a need for better understanding of what successful community mobilisation would look like and how community needs and ideas could continue to shape and lead action in specific localities or groups but within a system-wide approach.

*(iii) Can we develop an evidence base to underpin the work within communities?*

The challenges around an evidence base for community-based health promotion are by no means new ones, and there have been advances in evaluation theory and methodology for settings based approaches and other complex community initiatives [19]. Yet, there is a sense in which the ‘problem’ of evidence remains unresolved. Despite a degree of consensus about the need for a pluralistic approach to evidence within public health [20], many community-based health programmes will still face the burden of proof around evidence of effectiveness in order to access or maintain funding. The dilemma identified in 1990 by Hayes and Manson Willms [21] in relation to the Canadian Healthy Communities Project is still pertinent: ‘as it stands communities are given a double message: tackle issues of local concern, but evaluate progress with a common yardstick’ [21:165]. Evaluation is made more complex when scale



is sought but local flexibility is retained and when professionally-determined interventions give way to community-designed and led action. A shift in emphasis towards the role(s) of civil society in health highlights additional measurement issues when change processes are no longer limited to a defined intervention.

In summary, contemporary challenges for community-based health promotion require further consideration of what success would look like, what would be the function and design of interventions within a system-wide approach and how might evidence best be collected. These represent broad fields of debate for the health promotion community with few easy answers, however, one starting point is to examine programmes that have demonstrated successful community mobilisation and to unpack participation in these contexts. The next section draws on research carried out by the Centre for Health Promotion Research, Leeds Metropolitan University, UK, to discuss the nature of the community contribution.

### **Understanding the community contribution – examples from UK research and practice**

Community-based health promotion in the UK is highly diverse, occurring across different sectors, both governmental and non-governmental, and tends to be characterised by small scale, time limited projects rather than approaches that seek broader mobilisation of civil society [22]. Nonetheless there are some examples of volunteer health programmes that have achieved scale. Community health champions are volunteers who bring their social skills, their life experience and position of influence within communities to inspire and support others to engage in health promotion activities [11:38]. The Altogether Better programme, initially launched in 2008 in the Yorkshire & Humber region of England, has led the

development of the community health champion model in the UK [23]. The programme, which has focused on tackling health inequalities in relation to mental health and wellbeing, physical activity and healthy eating, uses an explicit empowerment approach delivered through local projects in communities and workplaces. Individuals receive training to develop their confidence and skills and are then encouraged to choose how they will motivate and support those around them to achieve better health. While mass mobilisation is sought, with over 18,000 champions recruited to date [23], the level of engagement varies. In research conducted with active champions, the main roles were: talking to people about health informally as part of their daily lives; providing more intensive support to individuals; and organising or participating in community activities, groups or events [24].

A further example of community mobilisation can be found in the Walking for Health programme. In contrast to Altogether Better community health champion approach, Walking for Health is standardised intervention focused on encouraging physical activity and addressing sedentary behaviour. A national programme of volunteer-led health walks was originally coordinated by Natural England, a governmental agency and part funded by the Department of Health, and in 2012 was transferred to two large UK charities - Ramblers & Macmillan Cancer Support [25]. The programme model is based on volunteers leading walks in their local community. Volunteers receive one day training around the health benefits of walking and how to organise a walk and then they independently lead walks, often working in partnership with other walk leaders. Like Altogether Better, there is some central coordination of training, organisation of walks and monitoring, but this is a primarily a community-delivered intervention. Walking for Health has demonstrated high levels of volunteer involvement and spread across different types of community in England. In 2010, data from Natural England showed that there were 11,000 active walk leaders, the majority of

whom were volunteers, and over 63,000 people regularly taking part in health walks [source Natural England cited in 18].

These two volunteer-led health programmes act as illustrative cases that allow us to ‘consider the contributions and capacities of civil society’[3] within community-based health promotion. Themes emerging from research with these programmes are supported by other studies around the lay role in public health [18]. Community members playing an active part in organising and delivering health activities bring valuable skills, knowledge and experience into their role. Core qualities identified by champions in a series of participatory workshops were: having empathy and being non judgemental; being approachable and friendly; listening and being a good communicator and having knowledge of the areas they were talking to people about [26]. These skills and attributes are of value to community-based health promotion and moreover are distinctive from professional, organisational or policy skills that may be associated with other sectors within a health system. Participation additionally creates pathways for individuals in terms of personal development, leadership roles, or progression to education and employment. Many of the champions were able to describe the transformational change that they had personally experienced from being involved [24]. This in itself can contribute to building community capacity for health as people take on leadership roles [27].

An important aspect of the community contribution is the social connections developed and strengthened by these volunteer roles. The concept of lay health workers as bridges or navigators between services and communities is a fundamental rationale for lay engagement to address inequities in health in underserved populations [28]. A further consideration is

how community members work to strengthen connections *within* communities. There is evidence that both champions and volunteer walk leaders have a role in connecting people to activities and supporting the development of social bonds in groups [18, 24]. What is significant here is these processes occur informally as well as through the formal activities run as part of the intervention. For example, walk participants taking part in focus groups described how they often befriended other participants, and at times offered support, both inside and outside the group activity [29]. Furthermore, how professionals define an intervention may not be how community members conceptualise it. When participants were asked to describe their group, the responses suggested that the walking group, purportedly a health intervention for physical activity, was seen as having an essential social function. The following quotation illustrating a common theme:

“We’re a big group of friends, social people who happen to walk on a Monday morning. Again it’s like secondary really, the walking.” [29:27].

Intervention boundaries need to be seen as fluid and developmental, as change processes will spill over to other parts of social life. Research conducted with three case study projects (walking for health, breastfeeding peer support and a neighbourhood-based community health project) found that many programme beneficiaries also described their voluntary assistance both in and out of formal projects [30]. The paper concludes that it is more appropriate to view participation within communities as a spectrum defined by increasing responsibility for others rather than a dichotomous state between active and passive roles.

## **Implications for research and practice**

Understanding the nature of participation by communities within a broader policy framework that seeks to expand and deepen the civil society contribution to health and wellbeing has implications for contemporary health promotion practice and research.

The two illustrative cases – Walking for Health and community health champions – suggest that health can be promoted in everyday settings, often by enhancing natural social and communication processes such as information sharing, befriending and organising. Using the continuum proposed by Eng et al. [31] for analysing lay health advisor strategies, these two programmes are clearly nearer the informal natural helping end than the formal paraprofessional end. Contemporary understandings of notions of community and the dynamics of participation, as discussed above, would suggest that emphasis needs to be on enhancing people's confidence to undertake natural helping roles in preference to designating certain individuals as natural helpers. More broadly recognition of the contribution of community members within the places where they live and work fits with the philosophy, values and practice of asset-based approaches to health [32]. It is perhaps timely to consider the common threads between asset approaches and a settings based approach working with communities and neighbourhoods.

Community-based interventions have to be able to accommodate participation that is contextual and fluid [12]. This moves away from the rigid programmatic approach to community engagement where community members are involved in instrumental fashion for defined roles. Yet this also needs to be balanced by an awareness that health programmes

capable of supporting community mobilisation are needed. Providing an infrastructure that supports recruitment, provides training and development, makes available support and supervision to people in their roles, and coordinates community activities is helpful [14]. The two cases show that it is possible for inclusive, empowering approaches to co-exist within programmes that have achieved scale.

Contemporary community-based health promotion needs to be more aspirational; we need to see beyond community-based interventions to the broader issue of how civil society can contribute to the health system, in line with the framework of 'Health 2020' [4]. The two cases also illustrate the importance of seeing the intervention as part of a wider ecology or system [17]. Critically the structures and networks that make up a public health system need to support connections between what people do in communities and how decisions are made. In practical terms, this implies creating interfaces where relationships can be formed and community voices can be heard. This fits with a multi-level approach to community involvement and governance reported in evaluations of healthy cities [1, 13].

Much of the literature around community-based health promotion has concentrated on the practice of community health work, but contemporary challenges additionally require consideration of how organisational actors within a public health system facilitate or constrain citizen involvement [22]. Investment in a community infrastructure is necessary to support wide engagement across diverse communities and this is unlikely to occur without reorientation of policy priorities. Drawing on the learning from settings approaches and understandings of complex systems, makes it possible to understand the multiple levels at which action needs to take place.

Finally the research implications are profound if communities are to be treated as a valuable part of an equitable public health system. Programmes that successfully mobilise communities and are embedded and sustained over time pose challenges for evaluation as measurement of effects may become more difficult because of the independent actions of natural helpers and the fluidity of participation. Cornwall argues that there is a need for greater understanding of the nature of participation in communities; who participates, why, how and what basis [12]. A paper developed from the 2009 Chicago conference on community intervention research argues that it is necessary to look beyond the measuring the impact of an intervention on the community [17:1412].

“Ecological and systemic thinking, then, not only considers the community as a multilevel, multisectoral, and multicultural context but also considers how structural and interpersonal relationships between the intervention and relevant community components affect the development and success of the intervention.”

Understanding the community contribution and what is happening over time as participation deepens and extends requires assessment of organisational and community level outcomes as well as individual level outcomes. The Chicago conference proposed community capacity as a central organising concept [17]. Criteria such as whether programmes have promoted social inclusion or strengthened networks could also be important for measures of success.

### **Concluding remarks**

This paper has explored questions of how community-based health promotion can adapt to a systemic approach to citizen involvement. Given contemporary understandings of the dynamics of community participation, there is a need to reframe community-based health promotion to reflect a shift from an ‘intervention driven’ perspective to a ‘people centred’

one [18]. This would involve recognising that the community contribution occurs in both formal roles and informal activity. There is a research agenda to understand the nature of successful community mobilisation and the influencing factors as well as effects. Health can be promoted through the efforts of volunteers within civil society, but advocacy is also needed to ensure that other parts of the public health system, notably public agencies, provide the necessary infrastructure to enable rather than control the growth and flourishing of community assets.

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